(b) *Limitation on administrative expenses.* No more than 10 percent of available funds shall be used for administrative expenses over the life of the contract with the PCIP, absent approval from HHS.

§ 152.33 Initial allocation of funds.

HHS will establish an initial ceiling for the amount of the $5 billion in Federal funds allocated for PCIPs in each State using a methodology consistent with that used to established allocations under the Children's Health Insurance Program, as set forth under 42 CFR Part 457, Subpart F, Payment to States.

§ 152.34 Reallocation of funds.

If HHS determines, based on actual and projected enrollment and claims experience, that the PCIP in a given State will not make use of the total estimated funding allocated to that State, HHS may reallocate unused funds to other States, as needed.

§ 152.35 Insufficient funds.

(a) *Adjustments by a PCIP to eliminate a deficit.* In the event that a PCIP determines, based on actual and projected enrollment and claims data, that its allocated funds are insufficient to cover projected PCIP expenses, the PCIP shall report such insufficiency to HHS, and identify and implement necessary adjustments to eliminate such deficit, subject to HHS approval.

(b) *Adjustment by the Secretary.* If the Secretary estimates that aggregate amounts available for PCIP expenses will be less than the actual amount of expenses, HHS reserves the right to make such adjustments as are necessary to eliminate such deficit.

Subpart G—Relationship to Existing Laws and Programs

§ 152.39 Maintenance of effort.

(a) *General.* A State that enters into a contract with HHS under this part must demonstrate, subject to approval by HHS, that it will continue to provide funding of any existing high risk pool in the State at a level that is not reduced from the amount provided for in the year prior to the year in which the contract is entered.

(b) *Failure to maintain efforts.* In situations where a State enters into a contract with HHS under this part, HHS shall take appropriate action, such as terminating the PCIP contract, against any State that fails to maintain funding levels for existing State high risk pools as required, and approved by HHS, under paragraph (a) of this section.

§ 152.40 Relation to State laws.

The standards established under this section shall supersede any State law or regulation, other than State licensing laws or State laws relating to plan solvency, with respect to PCIPs which are established in accordance with this section.

Subpart H—Transition to Exchanges

§ 152.44 End of PCIP program coverage.

Effective January 1, 2014, coverage under the PCIP program (45 CFR part 152) will end.

§ 152.45 Transition to the exchanges.

Prior to termination of the PCIP program, HHS will develop procedures to transition PCIP enrollees to the Exchanges, established under sections 1311 or 1321 of the Affordable Care Act, to ensure that there are no lapses in health coverage for those individuals.

PART 153 [RESERVED]

PART 154—HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

Subpart A—General Provisions

Sec.

Subpart B—Disclosure and Review Provisions

AUTHORITY: Section 2794 of the Public Health Service Act (42 USC 300gg–94).

SOURCE: 76 FR 29985, May 23, 2011, unless otherwise noted.

Subpart A—General Provisions

§ 154.101 Basis and scope.

(a) *Basis.* This part implements section 2794 of the Public Health Service (PHS) Act.

(b) *Scope.* This part establishes the requirements for health insurance issuers offering health insurance coverage in the small group or individual markets to report information concerning unreasonable rate increases to the Centers for Medicare & Medicaid Services (CMS). This part further establishes the process by which it will be determined whether the rate increases are unreasonable rate increases as defined in this part.

§ 154.102 Definitions.

As used in this part:

CMS means the Centers for Medicare & Medicaid Services.

Effective Rate Review Program means a State program that CMS has determined meets the requirements set forth in §154.301(a) and (b) for the relevant market segment in the State.

Federal medical loss ratio standard means the applicable medical loss ratio standard for the State and market segment involved, determined under subpart B of 45 CFR part 158.

Health insurance coverage has the meaning given the term in section 2791(b)(1) of the PHS Act.

Health insurance issuer has the meaning given the term in section 2791(b)(2) of the PHS Act.

Individual market has the meaning given the term under the applicable State's rate filing laws, except that where State law does not define the term, it has the meaning given in section 2791(e)(1)(A) of the PHS Act.

Product means a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State.

Rate increase means any increase of the rates for a specific product offered in the individual or small group market.

Rate increase subject to review means a rate increase that meets the criteria set forth in §154.200.

Secretary means the Secretary of the Department of Health and Human Services.

Small group market has the meaning given under the applicable State's rate filing laws, except that where State law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act; provided, however, that for the purpose of this definition, ''50'' employees is substituted for ''100'' employees in the definition of ''small employer'' under section 2791(e)(4).

State has the meaning given the term in section 2791(d)(14) of the PHS Act.

Unreasonable rate increase means:

(1) When CMS is conducting the review required by this part, a rate increase that CMS determines under §154.205 is:

(i) An excessive rate increase;

(ii) An unjustified rate increase; or

(iii) An unfairly discriminatory rate increase.

(2) When CMS adopts the determination of a State that has an Effective Rate Review Program, a rate increase that the State determines is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable as provided under applicable State law.

EFFECTIVE DATE NOTE: At 76 FR 54976, Sept. 6, 2011, §154.102 was amended by revising the definitions of ''individual market'' and ''small group market'', effective . For the convenience of the user, the revised text is set forth as follows:

§ 154.102 Definitions.

* * * * *

Individual market has the meaning given the term under the applicable State's rate filing laws, except that:

(1) Where State law does not define the term, it has the meaning given in section 2791(e)(1)(A) of the PHS Act; and

(2) Coverage that would be regulated as individual market coverage (as defined in section 2791(e)(1)(A)) if it were not sold through an association is subject to rate review as individual market coverage.

* * * * *

Small group market has the meaning given under the applicable State's rate filing laws, except that:

(1) Where State law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act; provided, however, that for the purpose of this definition, ''50'' employees applies in place of ''100'' employees in the definition of ''small employer'' under section 2791(e)(4); and

(2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage.

* * * * *

§ 154.103 Applicability.

(a) *In general.* The requirements of this part apply to health insurance issuers offering health insurance coverage in the individual market and small group market.

(b) *Exceptions.* The requirements of this part do not apply to grandfathered health plan coverage as defined in 45 CFR §147.140, or to excepted benefits as described in section 2791(c) of the PHS Act.

Subpart B—Disclosure and Review Provisions

§ 154.200 Rate increases subject to review.

(a) A rate increase filed in a State on or after September 1, 2011, or effective on or after September 1, 2011, in a State that does not require a rate increase to be filed, is subject to review if:

(1) The rate increase is 10 percent or more, applicable to a 12-month period that begins on September 1, as calculated under paragraph (c) of this section; or

(2) The rate increase meets or exceeds a State-specific threshold applicable to a 12-month period that begins on September 1, as calculated under paragraph (c) of this section, determined by the Secretary. In establishing a State-specific threshold, the Secretary shall consult with the State and may consider relevant information provided by other interested parties. A State-specific threshold shall be based on factors impacting rate increases in a State to the extent that data relating to such State-specific factors is available.

(b) The Secretary will publish a notice no later than June 1 of each year concerning whether a threshold under paragraph (a)(1) or (2) of this section applies to a State; except that, with respect to the 12-month period that begins on September 1, 2011, the threshold under paragraph (a)(1) of this section applies.

(c) A rate increase meets or exceeds the applicable threshold set forth in paragraph (a) of this section if the average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold.

(d) If a rate increase that does not otherwise meet or exceed the threshold under paragraph (c) of this section meets or exceeds the threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the threshold and is subject to review under §154.210, and such review shall include a review of the aggregate rate increases during the applicable 12-month period.

§ 154.205 Unreasonable rate increases.

(a) When CMS reviews a rate increase subject to review under §154.210(a), CMS will determine that the rate increase is an unreasonable rate increase if the increase is an excessive rate increase, an unjustified rate increase, or an unfairly discriminatory rate increase.

(b) The rate increase is an excessive rate increase if the increase causes the

premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage. In determining whether the rate increase causes the premium charged to be unreasonably high in relationship to the benefits provided, CMS will consider:

(1) Whether the rate increase results in a projected medical loss ratio below the Federal medical loss ratio standard in the applicable market to which the rate increase applies, after accounting for any adjustments allowable under Federal law;

(2) Whether one or more of the assumptions on which the rate increase is based is not supported by substantial evidence; and

(3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable.

(c) The rate increase is an unjustified rate increase if the health insurance issuer provides data or documentation to CMS in connection with the increase that is incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.

(d) The rate increase is an unfairly discriminatory rate increase if the increase results in premium differences between insureds within similar risk categories that:

(1) Are not permissible under applicable State law; or

(2) In the absence of an applicable State law, do not reasonably correspond to differences in expected costs.

§ 154.210 Review of rate increases subject to review by CMS or by a State.

(a) Except as provided in paragraph (b) of this section, CMS will review a rate increase subject to review to determine whether it is unreasonable, as required by this part.

(b) CMS will adopt a State's determination of whether a rate increase is an unreasonable rate increase, if the State:

(1) Has an Effective Rate Review Program as described in § 154.301; and

(2) The State provides to CMS, on a form and in a manner prescribed by the Secretary, its final determination of whether a rate increase is unreasonable, which must include a brief explanation of how its analysis of the relevant factors set forth in § 154.301(a)(3) caused it to arrive at that determination, within five business days following the State's final determination.

(c) CMS will post and maintain on its Web site a list of the States with market segments that meet the requirements of paragraph (b) of this section.

§ 154.215 Submission of disclosure to CMS for rate increases subject to review.

(a) For each rate increase subject to review, a health insurance issuer must submit a Preliminary Justification for each product affected by the increase on a form and in the manner prescribed by the Secretary.

(b) The Preliminary Justification must consist of the following Parts:

(1) Rate increase summary (Part I), as described by paragraph (e) of this section;

(2) Written description justifying the rate increase (Part II), as described by paragraph (f) of this section; and

(3) When CMS is reviewing the rate increase under § 154.210(a), rate filing documentation (Part III), as described by paragraph (g) of this section.

(c) A health insurance issuer must complete and submit Parts I and II of the Preliminary Justification described in paragraphs (b)(1) and (2) of this section to CMS and, as long as the applicable State accepts such submissions, to the applicable State for any rate increase subject to review. If a rate increase subject to review is for a product offered in the individual market or small group market and CMS is reviewing the rate increase under § 154.210(a), then the health insurance issuer must also complete and submit Part III of the Preliminary Justification described in paragraph (b)(3) of this section to CMS only.

(d) The health insurance issuer may submit a single, combined Preliminary Justification for rate increases subject to review affecting multiple products, if the claims experience of all products has been aggregated to calculate the rate increases and the rate increases are the same across all products.

(e) Content of rate increase summary (Part I): The rate increase summary must include the following as determined appropriate by the Secretary:

(1) Historical and projected claims experience;

(2) Trend projections related to utilization, and service or unit cost:

(3) Any claims assumptions related to benefit changes;

(4) Allocation of the overall rate increase to claims and non-claims costs;

(5) Per enrollee per month allocation of current and projected premium; and

(6) Three year history of rate increases for the product associated with the rate increase.

(f) Content of written description justifying the rate increase (Part II): The written description of the rate increase must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase and include the following:

(1) Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary; and

(2) Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

(g) Content of rate filing documentation (Part III): (1) The rate filing documentation must be sufficient for CMS to conduct an examination satisfying the requirements of §154.301(a)(3) and (4) and determine whether the rate increase is an unreasonable increase. Instructions concerning the requirements for the rate filing documentation will be provided in guidance issued by CMS.

(2) If the health insurance issuer is also required to submit a rate filing to a State in connection with the rate increase under State law, CMS will accept a copy of the filing provided that the filing includes all of the information described in paragraph (g)(1) of this section.

(h) If the level of detail provided by the issuer for the information under paragraph (g) of this section does not provide sufficient basis for CMS to determine whether the rate increase is an unreasonable rate increase, CMS will request the additional information necessary to make its determination. The health insurance issuer must provide the requested information to CMS within 10 business days following its receipt of the request.

(i) Posting of the disclosure on the CMS Web site: (1) CMS promptly will make available to the public on its Web site the information contained in Parts I and II of each Preliminary Justification.

(2) CMS will make available to the public on its Web site the information contained in Part III of each Preliminary Justification that is not a trade secret or confidential commercial or financial information as defined in CMS's Freedom of Information Act regulations, 45 CFR 5.65.

(3) CMS will include a disclaimer on its Web site with the information made available to the public that explains the purpose and role of the Preliminary Justification.

(j) CMS will include information on its Web site concerning how the public can submit comments on the proposed rate increases that CMS reviews.

§154.220 Timing of providing the Preliminary Justification.

A health insurance issuer must submit a Preliminary Justification for all rate increases subject to review that are filed in a State on or after September 1, 2011, or effective on or after September 1, 2011 in a State that does not require the rate increase subject to review to be filed, as follows:

(a) If a State requires that a proposed rate increase be filed with the State prior to the implementation of the rate, the health insurance issuer must submit to CMS and the applicable State the Preliminary Justification on the date on which the health insurance issuer submits the proposed rate increase to the State.

(b) For all other States, the health insurance issuer must submit to CMS and the State the Preliminary Justification prior to the implementation of the rate increase.

§154.225 Determination by CMS or a State of an unreasonable rate increase.

(a) When CMS receives a Preliminary Justification for a rate increase subject

to review and CMS reviews the rate increase under §154.210(a), CMS will make a timely determination whether the rate increase is an unreasonable rate increase.

(1) CMS will post on its Web site its final determination and a brief explanation of its analysis, consistent with the form and manner prescribed by the Secretary under §154.210(b)(2), within five business days following its final determination.

(2) If CMS determines that the rate increase is an unreasonable rate increase, CMS will also provide its final determination and brief explanation to the health insurance issuer within five business days following its final determination.

(b) If a State conducts a review under §154.210(b), CMS will adopt the State's determination of whether a rate increase is unreasonable and post on the CMS Web site the State's final determination described in §154.210(b)(2).

(c) If a State determines that the rate increase is an unreasonable rate increase and the health insurance issuer is legally permitted to implement the unreasonable rate increase under applicable State law, CMS will provide the State's final determination and brief explanation to the health insurance issuer within five business days following CMS's receipt thereof.

§154.230 Submission and posting of Final Justifications for unreasonable rate increases.

(a) If a health insurance issuer receives from CMS a final determination by CMS or a State that a rate increase is an unreasonable rate increase, and the health insurance issuer declines to implement the rate increase or chooses to implement a lower increase, the health insurance issuer must submit to CMS timely notice that it will not implement the rate increase or that it will implement a lower increase on a form and in the manner prescribed by the Secretary.

(b) If a health insurance issuer implements a lower increase as described in paragraph (a) of this section and the lower increase does not meet or exceed the applicable threshold under §154.200, such lower increase is not subject to this part. If the lower increase meets or exceeds the applicable threshold, the health insurance issuer must submit a new Preliminary Justification under this part.

(c) If a health insurance issuer implements a rate increase determined by CMS or a State to be unreasonable, within the later of 10 business days after the implementation of such increase or the health insurance issuer's receipt of CMS's final determination that a rate increase is an unreasonable rate increase, the health insurance issuer must:

(1) Submit to CMS a Final Justification in response to CMS's or the State's final determination, as applicable. The information in the Final Justification must be consistent with the information submitted in the Preliminary Justification supporting the rate increase; and

(2) Prominently post on its Web site the following information on a form and in the manner prescribed by the Secretary:

(i) The information made available to the public by CMS and described in §154.215(i);

(ii) CMS's or the State's final determination and brief explanation described in §154.225(a) and §154.210(b)(2), as applicable; and

(iii) The health insurance issuer's Final Justification for implementing an increase that has been determined to be unreasonable by CMS or the State, as applicable.

(3) The health insurance issuer must continue to make this information available to the public on its Web site for at least three years.

(d) CMS will post all Final Justifications on the CMS Web site. This information will remain available to the public on the CMS Web site for three years.

Subpart C—Effective Rate Review Programs

§154.301 CMS's determinations of Effective Rate Review Programs.

(a) *Effective Rate Review Program.* In evaluating whether a State has an Effective Rate Review Program, CMS will apply the following criteria for the review of rates for the small group market and the individual market, and

also, as applicable depending on State law, the review of rates for different types of products within those markets:

(1) The State receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination described in paragraph (a)(3) of this section.

(2) The State conducts an effective and timely review of the data and documentation submitted by a health insurance issuer in support of a proposed rate increase.

(3) The State's rate review process includes an examination of:

(i) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions; and

(ii) The health insurance issuer's data related to past projections and actual experience.

(4) The examination must take into consideration the following factors to the extent applicable to the filing under review:

(i) The impact of medical trend changes by major service categories;

(ii) The impact of utilization changes by major service categories;

(iii) The impact of cost-sharing changes by major service categories;

(iv) The impact of benefit changes;

(v) The impact of changes in enrollee risk profile;

(vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;

(vii) The impact of changes in reserve needs;

(viii) The impact of changes in administrative costs related to programs that improve health care quality;

(ix) The impact of changes in other administrative costs;

(x) The impact of changes in applicable taxes, licensing or regulatory fees;

(xi) Medical loss ratio; and

(xii) The health insurance issuer's capital and surplus.

(5) The State's determination of whether a rate increase is unreasonable is made under a standard that is set forth in State statute or regulation.

(b) *Public disclosure and input.* In addition to satisfying the provisions in paragraph (a) of this section, a State with an Effective Rate Review Program must provide access from its Web site to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases.

(c) CMS will determine whether a State has an Effective Rate Review Program for each market based on information available to CMS that a rate review program meets the criteria described in paragraphs (a) and (b) of this section.

(d) CMS reserves the right to evaluate from time to time whether, and to what extent, a State's circumstances have changed such that it has begun to or has ceased to satisfy the criteria set forth in paragraphs (a) and (b) of this section.

PARTS 155–157 [RESERVED]

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

Sec.